

HIV/AIDS IN NIGERIA
SITUATION, RESPONSE, AND PROSPECTS

Key Issues

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Key HIV/AIDS Indicators in Nigeria

Population in 2003	126 million
Percentage of 15-49 population HIV+ (2001)	5.8%
Lowest State Prevalence:	1.0%
Highest State Prevalence:	15.0%
Prevalence in Age group most affected: 20-24	6.5%
Estimated Population HIV+ in 2001	3.47 million
Estimated cumulative number of deaths due to AIDS by 2002	1.4 million
Estimated number of AIDS orphans in 2003	1.3 million

History

Nigeria's first case of AIDS was diagnosed in a 13 year old girl in 1986. At the time the response was to deny the fact that this was a significant problem. Though a National Expert Advisory Committee on AIDS (NEACA) was established in the same year, little else was done. No concerted attempts were initiated to prevent the spread of the epidemic. Later in 1988 the advisory board was replaced with the National AIDS and STD Control programme under the Federal Ministry of Health. Unfortunately this was not well funded. Consequently the epidemic smouldered largely unnoticed until it reached significant levels.

The main perception was that this was a disease of the western world associated with men who had sex with men. The first sentinel survey conducted in 1991 showed the HIV prevalence to be 1.8%. Even then because there was very little visible evidence of AIDS, the country took only a few essentially cosmetic actions. Public enlightenment campaigns attempted to scare people into adopting safer sexual practices but these were limited and fell on the deaf ears of a largely disbelieving public. Unfortunately, with benefit of hindsight, it is now realised that this scare mongering led to the high levels of stigma and discrimination towards those living with HIV/AIDS that became so rife.

Serial sentinel surveys were carried out thereafter in 1993, 1996, 1999, 2001, with the latest for 2003 currently under way. The HIV prevalence rose steadily until it reached 5.8 in 2001. By 1996 when the prevalence was 4.5%, the health authorities took note of this fact and catalysed the creation of

states AIDS control programs all health sector driven, but with very limited public awareness and mobilization campaigns. Funds allocated for HIV interventions were largely insignificant and what little that took place was funded essentially through donor assistance. The death of the popular musician, Fela Anikulapo Kuti and the public declaration by his family (headed by his elder brother, a former Minister of Health) that he died of complications of AIDS helped shock Nigerians into accepting that the epidemic was real and very much with us.

Thus in 1997 the first HIV/AIDS policy was written and adopted under the Federal Ministry of health. Various programmes were set up to control the epidemic which largely focused on prevention activities. These included strategies to increase the awareness and knowledge of citizens on HIV/AIDS; increasing knowledge of protective measures to take including the use of condoms; and the control of sexually transmitted infections (STI) through various means including the early detection and correct management of STI utilizing the syndromic management approach.

With further rise in the HIV prevalence in subsequent surveys, it became obvious that further drastic steps needed to be taken. When compared to many other Sub-Saharan African countries, Nigeria's epidemic was comparatively young but due to her large population, the burden was already telling. In line with global thinking it became apparent that the health sector could not fully tackle the many challenges thrown up by this epidemic that was threatening to reverse many of the developmental gains in the developing nations. A multi-sectoral, multi-tier, and multi-disciplinary approach was needed to maximize resources available for effectively combating this threat.

In recognition of these, the President of Nigeria in January 2000, established a Presidential Committee on AIDS (PCA) headed by himself with key sectoral Ministers as members, and the National Action Committee on AIDS (NACA) located within the Presidency to facilitate the multisectoral approach to controlling the epidemic and underscore the importance he personally attached to this challenge. After a few false starts occasioned by the lack of clarity of roles between NACA, the Federal Ministry of Health and other sectors, NACA commenced executing its role of facilitating and coordinating the national multisectoral response. One of the earliest steps was the development of an HIV/AIDS Emergency Action Plan (HEAP) which included strategies for creating an enabling environment for HIV interventions, and specific interventions to control the spread of the infection, provide care and support for the infected and mitigate the impact of HIV/AIDS in the country.

Political Support

There is certainly a high level of political support for the control of HIV/AIDS at the federal level. This is reflected in the President's public statements and continental leadership for HIV/AIDS global advocacy. The current government has also budgeted more funds for HIV/AIDS control than any of their predecessors. The President has also led by personal example in allowing his picture and his utterances be used in public awareness campaigns against HIV/AIDS. Ministers in his cabinet have also from time to time openly expressed the country's determination to overcome the epidemic in support of the Presidents' vision and efforts.

The amount of support seen at state levels are however not as high as that seen at the federal. State governors are less visible in their campaign against HIV/AIDS. Many states have left the leadership of the response to the epidemic to wives of the state governors who use the medium of non governmental organisations (NGOs) in which they have personal interests to mobilize resources for their activities in their capacity as heads of the newly created State Action Committees on AIDS (SACA). The conflicts of interest that arise from this strategy create wrong perceptions of the true intent of all those involved and often cannot be sustained beyond the terms of the elected governors.

Though all states except one have created State Action committees on AIDS¹ which have membership from a wide range of organisations such as seen at the federal level, most do not understand their roles and several are still led by the health sector or health professionals. Consequently, the other sectors have not been able to accept ownership of the response and contribute little to funding these new structures. Where non-health professionals have headed these SACAs, they have also tended to have similar conflicts with the health ministries as was experienced at the federal level.

The question as to who should head the SACA has been raised. Though the general consensus is that it should be run from the Governor's office, practise is much different. Some have placed it under the Office of Secretary to the State Governments and others under the Ministry of Health. Positioning it such usually limits the effectiveness and visibility of the SACA and affects the funding.

In considering the sustainability of the present increasing level of commitment to the HIV/AIDS response it is important to gauge the level of commitment of political parties to the HIV/AIDS national response. Unfortunately this is very low. No party made the HIV/AIDS epidemic an issue for

¹ National Action Committee on AIDS 2003; Capacity review of SACAs and LACAs – NIGERIA; Baseline Assessment Report

political discourse or debate. It was not found on the manifesto of parties neither was it articulated as a problem that needed urgent attention. When Nigerian were asked to gauge the level of support political parties gave to HIV/AIDS issues, they scored lowest of all social institutions². When persons considered knowledgeable about the national response were asked a similar question they also rated their commitment low³

Though the country has taken a proactive stance in its program against HIV/AIDS, the funding of activities is not a very reflective index of commitment. Most of the funding for HIV initiatives is provided by donor organisations, bilateral and multilateral development partners. The President had directed that all federal ministries should include HIV activities as line items in their budgetary submissions, but this is yet to happen as the appropriations committees of the national assembly have consistently refused to give approval. Without such approval, most sectoral ministries have great difficulty committing resources for HIV/AIDS activities. NACA has held sensitization and advocacy activities with the top hierarchy of the public sector including members of the national council of state (that has all the state governors as members) as well as with the national assembly that it is hoped that some of these problems may be overcome in the 2004 budgets. While this is a step in the right direction, one should also note that there can be major differences between budgetary allocation and the actual release of funds for expenditure.

Ad Hoc committees on HIV/AIDS have been set up in both arms of the National Assembly but are yet to pass any bills in support of the Response. In addition, confusion still exists as to whether these committees are better considered as sub-committees of the statutory health committees or stand-alone committees. A bill for the establishment of a statutory body to coordinate the nation's response to the HIV epidemic and replace NACA is still undergoing review in the House of Representatives. Efforts to get it passed earlier were delayed due to the multiplicity bills submitted for the same purpose by different actors with different interests from NACA, the Federal Ministry of Health and independents in the national assembly. These have all been harmonized and have gone through preliminary readings and one public hearing. In spite of this, the bill is yet to be passed. Existing and developing political parties have also shown very little interest in the HIV/AIDS response.

² Federal Ministry of Health 2003: National HIV/AIDS and Reproductive Health Survey

³ Federal ministry of Health 2003: The Policy Environment Score Measuring the Degree to Which the Policy Environment in Nigeria Supports Effective Policies and Programs for Family Planning, Adolescent Reproductive health and HIV/AIDS/STI: 2002

In determining political support, it may be misleading to gauge support by the words of government officials only. It may be more appropriate to use other indices such as amount of resources dedicated to activities and the evidence of programmes being implemented. If one were to use the AIDS program effort index to measure the perceived level of commitment as judged by persons working in the area of HIV/AIDS in the country. The API for the country has been as high as seen in most other African countries. There however is a major difference in the amount of political commitment and the resources made available for HIV/AIDS with the latter rated poorly though improving.

Popular Support

Nigeria is a large and heterogeneous country with numerous ethnic groups and languages. Public knowledge and opinions towards the HIV/AIDS epidemic and the current interventions being used vary with location. Attitudes towards present HIV/AIDS initiatives are more positive in the urban areas and southern zones of the country. Religious groups are essentially opposed to condom promotion and the introduction of sexuality education curricula in primary and secondary schools. Talking about sexual issues is not the norm in most ethnic groups. Condom advertisements are considered by many as likely to increase promiscuity and the sexual activities among youth by negating moral teachings of society and the two major religions of Christianity and Islam. Though NACA and her developmental partners and NGOs have tried to provide evidence from studies to indicate that in the era of globalisation, empowering youth with information and options is more effective than concentrating only on moral weapons for instituting behaviour changes that have a lasting protective impact on the epidemic, the conservatives remain unconvinced. In the National HIV/AIDS & Reproductive Health Survey only 59.9% of persons believed that Christian organisations were in support of HIV/AIDS activities; figures for Islamic groups and traditional leaders was even worse which was 49.6 % and 57.1% respectively⁴

NGO leaders have shown the highest support for HIV/AIDS and are the major implementers of activities. They have been in the fore-front of the battle against this epidemic from inception even when there was little or no government support or understanding. Unfortunately many though well intentioned, lack the financial or human technical capacity to make the desired impact. Fund raising skills and financial accountability have also been problems, as many find it difficult to raise funds or account for them well after they have been disbursed. A lack of knowledge of what works and what

⁴ Federal Ministry of Health 2003: National HIV/AIDS and Reproductive Health Survey

doesn't remain problematic as very few evaluate their programmes. There was until recently no structure or system to coordinate their output as to ensure maximal effect from their activities. NACA is articulating plans to ensure their input is factored in as part of the Nigerian response but this could be a long time in coming.

Donors and International Development Assistance

Nigeria does not lack for donor assistance. United Nations (UN) agencies, the World Bank, United States Agency for International Development (USAID), British Department for International Development (DFID), Canadian International Development Agency (CIDA), Japanese International Cooperation Agency (JICA), European Union (EU), the Italian Cooperation, including Foundations such as the Bill and Melinda Gates Foundation, Mac-Arthur Foundation, Ford Foundation, Packard Foundation, Gede Foundation etc have all increased their financial and programmatic support for Nigeria's HIV/AIDS efforts. The amount given is also steadily rising. A matter of concern is that the funds received per capita is much smaller than most other sub-Saharan African countries with the same state of the epidemic.

Nigeria has always had the problem of being one of the poorest countries per capita but one of the highest gross national product on the African continent. This has led to misrepresentation and misinterpretation of the countries needs. Donor assistance though much is only able to achieve little in the face of the high population, the high population growth rate, and the present high debt burden and the relative economic stagnancy.

Though the funding is rising and the donor base continues to expand, the large population and the fast growth rate is begging for more and faster.

Funding

The disbursements from the World Bank's IDA (International Development Association) credit scheme for Nigeria have already commenced as part of the Bank's global Multi-country AIDS Assistance Project (MAP). Four states have achieved credit effectiveness and have commenced drawing down on the facility. The remaining 18 are expected to achieve credit effectiveness shortly. NGOs have started receiving funding through the HIV/AIDS Fund scheme as part of this IDA credit. Sectoral line ministries have also been receiving disbursements from this scheme. The total amount of

funding to be disbursed through the IDA credit is \$90.3 million over a period of 5 years. It is obvious that it is not money to be relied upon to execute the national response but should rather complement other funding.

The country has had 3 proposals submitted to the Global Fund for AIDS, TB and Malaria approved to enable the scaling up of the prevention of mother to child HIV transmission (PMTCT) initiatives, expansion of the anti-retroviral therapy (ARV) scheme, in addition to funds to catalyze and rapidly mobilize civil society responses to the epidemic. These funds were initially delayed while steps were being taken to select appropriate principal recipients (PRs) and developing and understanding the procedures and functions of the Country Coordinating Mechanism (CCM) for managing these processes in the country. Other proposals have been submitted to the Global fund for which approval is awaited.

Nigeria is also a beneficiary of funding from the United States Presidential Initiative on HIV/AIDS which commits America to spending \$15 billion over the next three years for funding and rapidly scaling up HIV/AIDS initiatives in 14 priority developing countries as well as others to lesser degrees. This initiative is expected to contribute significantly to Nigeria's VCT, PMTCT and ARV programmes and is supported by several US government agencies led by the Centre for Disease Control (CDC), USAID and their partners. The amount that will be received by Nigeria from this initiative is not known.

Other funding agencies previously highlighted are also contributing and committed to sustaining substantial funding for periods varying between 3 and 8 years. Of note would be the contributions of the USAID, DFID, and the Bill and Melinda Gates Foundation through the AIDS Program Initiative in Nigeria (APIN) led by the Harvard School of Public Health.

Nigeria needs resources now to fund its HIV/AIDS activities. The HEAP which was developed in 2001 was not fully implemented for various reasons. One of the major reasons was the funding gap. The plan articulated about 300 activities which would have required out of which less than 60% have been actualised. Many reasons can be adduced for this including lack of institutional capacity to implement, however even the lack of institutional capacity could be blamed on lack funding as many highly skilled and trained persons are unemployed; unemployment in Nigeria is presently estimated to be above 10%.

Policies and Plans

In 2001, a 3 year *HIV/AIDS Emergency Action Plan* (HEAP) was formulated, adopted and is now being implemented. This Plan was built around two strategic components: *CREATION OF AN ENABLING ENVIRONMENT* and *SPECIFIC HIV/AIDS INTERVENTIONS*⁵. The NACA is expected to contribute significantly to the creation of the “enabling environment”, through coordination of the specific interventions of implementing agencies for better impact. Consequently, it is not expected itself to be involved with program implementation activities leaving that to sectors that have the comparative advantage for maximizing on program results and impacts. The HEAP required a more functional monitoring and evaluation mechanism to make this coordination effective and results oriented. A monitoring and evaluation plan was not put into place at the time of its formulation. This has led to most of the activities not being monitored and an inability to state categorically which activities have been carried out and what the effects of these activities has been. This HEAP is expected to end in 2004 by which time it is hoped that a new plan will developed and become operational which should be based on lessons learnt from the experiences of implementing HEAP. Unfortunately without a good M&E learning from experience may be less objective than anticipated. No midterm evaluation of the implementation of the HEAP was done. At preset there is no indication that an end term evaluation is being planned. If Nigeria is to improve its HIV/AIDS programming, it will be necessary to develop a willingness to not only monitor the progress and process of implementing the HEAP but also evaluate the outcome of plans

A review of the 1997 HIV/AIDS policy originally put together under the auspices of the Federal Ministry of Health began in 2001. The review was undertaken with technical assistance from the POLICY Project funded by USAID and involved a wide range of stakeholders. This policy entrenched the multisectoral approach and called for the establishment of a statutory body to coordinate and facilitate the national HIV/AIDS response. The policy’s main objectives were to:

- Promote a national multisectoral and multidisciplinary response to the epidemic in addition to the establishment of an appropriate legal and institutional framework for its coordination;
- Identify sectoral roles and assign responsibilities for the implementation of programmes based on sectors’ comparative advantages and core competencies;
- Increase awareness and sensitisation among the general population about HIV/AIDS;
- Foster behaviour change as the main means of controlling the epidemic;

⁵ National Action Committee on AIDS 2001; HIV/AIDS emergency Action Plan

- Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected;
- Provide access to cost-effective care and support for those infected, including anti-retroviral drugs;
- Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the Republic;
- Remove all possible barriers to HIV/AIDS prevention and control.
- Empower people infected and affected by HIV/AIDS through training, counselling, and education to cope with their circumstances.
- Develop standards and guidelines that lead to the institutionalisation of best practices to mitigate the impact of AIDS.
- Stimulate research, monitoring and evaluation of programs, relevant documentation of activities related to the epidemic and the dissemination of information generated to stakeholders and the general population.
- Ensure that prevention programmes are developed and targeted at vulnerable groups such as women and children, adolescents and young adults, sex workers, long distance commercial vehicle drivers, prison inmates, migrant labour etc⁶.

This policy was formally launched by the President of Nigeria on the 4th of August 2003. Active dissemination of this policy is now underway and will serve as the framework for developing specific sectoral policies.

One noticeable input of the policy formulation process was the wide stakeholder participation and the wide level of consultation. In spite of this many persons consider themselves distant from the policy making process. Many NGOs claim not to have been consulted during the process although they were represented through their umbrella group. The same has been stated by some religious organisations that were equally invited. This could mean that they do not consider their umbrella organisations as speaking for them or their umbrella organisations not giving enough feedback after returning from their assignments. This is of critical importance as the process was designed to ensure ownership by all.

⁶ Federal Government of Nigeria 2003. The National HIV/AIDS Policy

The policy tried to fill in gaps that had been identified in the 1997 'health sector' HIV/AIDS policy. The previous policy had made very little mention of care and support for persons living with HIV/AIDS, and even less on HIV/AIDS impact mitigation.

While the revised policy articulates better the country's intention to provide care for PLWHA, it does not state any preferential treatment. The country commits itself to make all forms of treatment available but does not commit itself to subsidising the cost of care. The country states a desire to empower the PLWHA but does not commit itself to anything beyond providing counselling, mobilisation of community responses and protection of their rights. The targets for care and support are stated in terms of percentage of states with facilities offering ARV and PMTCT services rather than the number or proportion of Nigerians that access them. This could lead to a situation in which many targets could be achieved without any real effect on the population or the diseased state being made.

Though the policy was only launched recently some persons have already started questioning statements made by the policy. The policy admitted that most HIV/AIDS was transmitted through sexual intercourse which was largely heterosexual. Associations of men who have sex with men assert that homosexual intercourse is also a significant mode of transmission through which HIV was being transmitted and the denial of this fact could deny such a high risk group the necessary attention and programming. The same could be said for intravenous drug users (IDUs). In Nigeria very few studies have been done on IDUs and there was no evidence of a higher risk of infection amongst this group. In the case of men who have sex with men (MSM) no study has been carried out due to the difficulty in assessing such a group of people in a country that generally considers the act an abomination. The rights of the sexual minority are not protected in Nigeria. Though stigma expressed towards PLWHA is now receiving considerable attention, the prejudices towards men having sex with men still quite high.

Structure and Systems

National Action Committee on AIDS

Like many other developing countries, Nigeria has passed through several phases in her response to the epidemic. The stages included an initial period of denial; a largely medical response; a public

health response; and now a multisectoral response that focuses on prevention, treatment and impact mitigation interventions.

The Government of Nigeria established the National Expert Advisory Committee on AIDS (NEACA) in 1987 under its first Medium Term Plan (MTP1). In 1988, this advisory board was replaced by the National AIDS and STDs Control Programme (NASCP) coordinated by the FMOH. This health led response which was initially coordinated by NASCP still exists but is now responsible solely for the health sector component of the national response to HIV/AIDS. In January 2000, the government of Nigeria realizing the seriousness of the situation facing Nigeria established the Presidential Council on AIDS (PCA) and the multi-sectoral and multi-disciplinary National Action Committee on AIDS (NACA).

NACA is situated structurally within the Presidency under the supervision of the office of the Secretary to the Government of the Federation (SGF). It has been given the role of coordinating and facilitating the national response and ensuring that those entities responsible for the implementation of specific activities receive the financial, organizational, and human resources support required to undertake and complete assigned activities in a multi sectoral environment with fewer bureaucratic bottlenecks and delays. In addition, NACA is responsible for coordinating the timely and effective execution of the HIV/AIDS Emergency Action Plan as well as future plans when they come into effect. In all instances, NACA is expected to monitor and report upon progress achieved in responding to identified objectives. In its role as coordinator of the HEAP, NACA shares fiduciary responsibility with implementing agencies in the interest of ensuring transparent and accurate reporting on the utilization of financial and material resources.

NACA is also expected to build up the institutional capacities of State action committees on AIDS (SACA) and the Local Government Areas Action Committees on AIDS (LACA). These institutions when sufficiently capacitated, will undertake to advocate and support the development of HIV/AIDS activities and initiatives originating at the state and local levels. This role includes the mobilization of resources, advocating the removal of barriers (socio-cultural, informational and systemic) as well as catalyzing community responses. It will also coordinate specific preventive, care and support interventions while not directly implementing them.

NACA as a committee was formed to include representatives from an initial 10 line ministries, some parastatals, as well as representatives from Civil Society Organisations, PLWHAs, Faith-based organizations, the organized private sector and members of the academia. The representation in

NACA is largely public sector and persons from the non public sector are largely under represented. In recent times the National Business coalition against AIDS an organised private sector response to HIV/AIDS has emerged. It is hoped that they will have representation on NACA. The Faith based organisations have also recently developed a response. Their representation is also expected soonest. The latter is already entrenched in the HIV/AIDS policy. Other important representation needed will include women groups which are not represented, youth groups, and the organised labour. The question has been raised what number of persons are considered optimum to form the committee. There is a desire to keep the committee within manageable numbers and still ensure adequate representation of all stakeholders. The answer is still up in the air. Many other stakeholders have considered their non-inclusion as an oversight.

Another group referred to as the Expanded Theme Group which developed from the UN Theme Group and includes representatives of all the UN agencies, bilateral and Multilateral donor agencies, balanced with representation from the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), the Civil Society Consultative Group on HIV/AIDS in Nigeria (CiSCGHAN), and select members of NACA that includes the Federal Ministry of Health. This group attempts to coordinate donor activities and utilization of resources. It advises NACA and serves as a ready mechanism for resource mobilization and technical support for programs.

Staffing

NACA has had one major limitation; the lack of adequate technical and support staff to it execute its mandate. The organisational structure was not well delineated at the time of its formation. There was a desire to employ staff who had prior experience and training in HIV/AIDS. They would then train those under them while carrying out functions relevant to the Secretariat of NACA. This was to fast track the process of implementation of all coordination related activities. Unfortunately the secretariat was never able to recruit enough technical staff due to the bureaucratic difficulties that existed at the time. Consequently, NACA has not fared well in effectively coordinating and monitoring the national response. NACA's main achievements to date have largely been the role of mobilising resources and facilitating community responses, including those that will be initiated by the public sector, organised private sector and the faith based organisations.

In 2002, NACA carried out an institutional assessment of itself under advice of the expanded theme group and technical assistance provided by a group of donor organizations led by DFID⁷. Through this assessment it was recommended that 4 directorates should be established in NACA. These were the directorates of Administration and Finance, Coordination and Support, Policy, Strategic and Communication, and Response Monitoring. Subsequently, provision was also made for the recruitment of a private-public sector liaison officer to inter-phase with the newly established Business Council, and a gender specialist. These positions are to be supported for an interim period of two years by this consortium of donor agencies to ensure that the proposed compensation plans attract high quality high calibre personnel who could immediately contribute to accelerating the momentum of the National response. It is the expectation that at the end of this process, appropriate legislation, structures and systems would have been in place for the new agency to continue the support for these positions. The personnel recruited to take charge these are expected to commence work in November 2003.

Challenges

The change in the national response from a health sector led response to a truly multi-sectoral one was not without difficulty. There was initial resistance from the health sector which saw this change as resulting in a loss of their sphere of influence, access to and control of resources. This was made even harder by the fact that NACA seemed to take on the role of both coordinator and implementer at inception as the roles were not initially well defined. It also lacked capacity in terms of staffing to do the work it had been mandated to undertake. The rift was worsened by later attempts by some stakeholders to get NACA placed under the jurisdiction of the Federal Ministry of Health so that a cabinet rank minister could speak on behalf of the organization at meetings of the Federal Executive Council. Donors and other stakeholder resistance to such a change resulted in maintenance of the status quo.

It is hoped that the new institutional assessment and reorganization which gives NACA the task of coordination only and not of implementation will eliminate these teething difficulties. NACA is expected to be seen to help every sector achieve their objectives within their sectors, rather than to be seen as competing with sectors for sectoral roles. It is also expected to be seen as a facilitator and coordinator rather than as a command and control unit.

⁷ Wendy Roseberry 2003. Review of the Government of Nigeria's Institutional Arrangement for the management of the HIV/AIDS program

NACA, though it has the backing of the presidency is still a “committee” without a legal and statutory status. As a result of this, it receives no direct funding. Funds are therefore sourced through the office of the Secretary to the Government. This delays allocation of government approved funds which affects the fast tracking of HIV/AIDS initiatives and negates one of the initial purposes for its creation. HIV/AIDS is supposed to be an epidemic which should demand emergency actions to bring it under control.

There has also been some confusion as to what constitutes NACA: the secretariat or the committee. The Committee had until recently, been made up of largely junior representatives or proxies of nominated members from the various ministries and institutions. Many did not have the authority to ensure that their ministries or organisations took seriously, the decisions reached at NACA meetings. The present HIV/AIDS policy states that representatives of the ministries should be of no less a rank than Director within a ministry and similar positions for other organisations. It is hoped that this will lead to increased adoption of deliberations that occur at NACA meetings.

The constituency of members is also seen as a problem as most of the members are civil servants. Top ranking civil servants may not really reflect the nation. It is believed that representatives of various groups such as professional organisations, traditional leaders, religious leaders and leaders of industry and the academia may give a better reflection of a committee that is expected to represent the national response. The domination of civil servants could mean a desire to maintain a conservative line, an increase in bureaucracy, increased wastage and a less effective committee. Others are of the opinion that the committee should be made up of mainly technocrats who understand the situation and are able to make useful contributions. While the fear of domination by the civil servants is understandable their inclusion is also reasonable. It might be necessary to include more representation from other groups to allay such fears.

Institutional Capacity Building

One of the major challenges in the national HIV/AIDS response is the limited capacity in country to plan, implement, and monitor HIV/AIDS programs. A good example is the already stated fact that NACA, after almost 3 years in existence, is yet to have a fully staffed secretariat. The country’s educational system has suffered from years of neglect. The few skilled graduates prefer to utilise their skills abroad for better remuneration than is obtainable in Nigeria. Even if Nigeria had all the money needed to upscale the initiatives it was presently carrying out, staffing the projects with skilled

personnel would be a major challenge. Previous attempts to use “interim staffing arrangements in other programs have not had the desired effect.

Facilities, especially for care and support are also quite limited. In a country of with over 29 million women of reproductive age of which 2.4 million of them are estimated to be living with HIV, only 11 PMTCT centres have been set up.

Virtually all the international donor and development agencies give some support for capacity building. Support in this area focuses mainly on building personnel capacity through training workshops or sponsorship to attend and participate in international conferences. A few institutions have also provided support for the establishment of physical structures such as specialized research laboratories, and provision of vehicles, computers and other equipment. The key players here are USAID, DFID, UNAIDS, UNICEF, UNDP, MacArthur Foundation, Ford Foundation and the Bill and Melinda Gates Foundation through the Harvard led APIN.

The large size of Nigeria, combined with years of neglect under successive military governments, has however made the contributions to date from all players is yet to make enough skilled hands available. The needs remain great. Unfortunately most persons trained are likely to seek better opportunities as a result of their improved capacity, leaving the institutions with fewer trained hands than actually trained.

Implementers

The country has adopted a multisectoral approach through the HEAP and the HIV/AIDS policy. Various sectors of the country are therefore expected to develop initiatives based on their comparative advantages. The various expected implementers of the HEAP and subsequent plans include federal and state line ministries and parastatals, civil society organisations, faith based organisations, and people infected or affected by HIV/AIDS. One objective of the policy is to inculcate in all stakeholders the idea that they everyone has a significant role to play in the control of the HIV/AIDS epidemic and its effects. The aim is to mainstream HIV/AIDS into activities and initiatives by various organisations. The hope is that most initiatives will be undertaken with the thought on how such activities could further the cause of the national response. Two recent additions to the national response are the private sector HIV/AIDS Business Council and the Council (Interfaith Forum) of faith based organisations.

Organised Private sector

Private sector leaders have only recently seen the need to get actively involved in the HIV/AIDS national response outside their workplaces. In July 2003 the President of the Federal Republic of Nigeria held a business forum on HIV/AIDS during which a private sector HIV/AIDS business initiative was launched which in turn has led to the establishment of a Nigerian HIV/AIDS Business Council. The process of articulating the structure and the agenda is presently still being worked out.

The acceptance of their role notwithstanding many of the organisations would prefer to provide money for HIV initiatives anonymously believing that the stigma around HIV/AIDS could taint the names of their companies leading to decreased sales and profit. This perception is however progressively changing and increasing large multinational corporations like Coca-Cola and MTN are now openly associating their brands and products with the National HIV/AIDS response.

The factors driving the Business Forum initiative are the presidential commitment to control HIV/AIDS epidemic and perhaps the social responsibility of the business community to the country. There is yet to be enticements such as tax relief for monies spent on HIV/AIDS. Pharmaceutical companies also do not receive any relief for the importation of ARV which could have resulted in price reductions for the end user.

Several organised private sector organizations have been involved in the control of HIV/AIDS within their workplaces through various initiatives; some not well thought out and with potential for stigma and discrimination and others supportive of the national response.

The statutory pre-employment medical test utilized by many employers of labour as part of criteria for recruiting new employees was updated to include HIV screening by several of these organizations. This and the routine annual medical evaluation have been used by several of these companies to determine employability and career enhancement. This clearly constitutes an invasion of the privacy of job applicants and is a definite violation of the rights of both prospective employees and staff being evaluated for promotion or other benefits. Confidentiality and privacy have been overlooked. Ethical issues around pre-test counselling and privacy of the affected individuals has been ignored by the medical retainers or health establishments of these companies. Commendably, a few large corporations have recognized the harm created and have abolished such practices. Unfortunately though, such practices still persist in several other organisations.

In addition, some of the larger international companies now have prevention, care and support programs, including workplace policies that provide for temporary reassignment to other tasks during ill episodes and the provision of anti-retroviral therapy. They have also recognized their social responsibilities to their host communities and opened their doors for partnership with NGOs more familiar with working on communities' prevention programs. These however are a minority, most are still in denial of HIV/AIDS and refuse to address the situation.

Faith Based Organisations

Many faith based organisations have been actively involved in HIV/AIDS initiatives, predating NACA. However their responses were isolated and not coordinated with the national response. Occasionally they worked in manners that were not complimentary to the national goals and objectives e.g. promoting faith and miracle healing that interfered with care seeking for those infected. A few of these faith based organisations (FBOs), especially the Catholic Church developed successful initiatives that the other faiths and organisations could benefit from, but these were not shared.

In April 2003, NACA invited the major faith based organisations in Nigeria to a consultative forum for experience sharing among themselves, understanding of the national response, their potential contributions and to learn from what their peers in other countries with more mature responses had been able to achieve. As a result of this meeting, an Interfaith HIV/AIDS Council evolved through which faith based organisations could contribute to the national response. Such contributions could include initiatives to maximize on their potential to reach large segments of the population through the preaching, and the provision of spiritual counselling and care and support services for which most religious institutions are known comparative advantage. Such messages and activities are also expected to contribute significantly in reducing stigma and discrimination within their membership.

Due to the large number of groups within Christian and Muslim faiths in Nigeria, it is difficult to critically assess the effect of religions on the national HIV/AIDS response. It must however be stated that while many good influences are gradually being manifested, especially in the "care and support" initiatives, a lot of obstacles have been imposed by the moral creeds. The banning of prostitution in states that have adopted the Sharia Law has led to prostitution going underground. This makes it even more difficult to reach this high risk group.

The constant attempts by major religious groups to “put down” the use of condoms as a means of protection also impacts negatively on the national response. Earlier in the epidemic many churches adopted a compulsory HIV/AIDS test before marriage. This violated the rights of their members and exposed those found positive to stigma and discrimination. Some of them even stated that those found positive could not marry in the church, a factor that even increased the stigma and discrimination and violated their rights to marry and right to spiritual support. Though most of the leadership at the highest levels have recanted this decision, it is still practised in many of their parishes.

Preventive Interventions

Awareness and Sensitisation

One of the major strategies of the HEAP is the removal of barriers to the provision of HIV/AIDS interventions thereby creating an enabling environment for the delivery of high effective and efficient services. One of these barriers was the unavailability of accurate, up-to-date information that reached the generality of the population on how they could protect themselves and their communities from the effects of the epidemic. Though a comprehensive and coordinated communication strategy is still being developed, NACA and a few organizations have attempted to orchestrate a few massive awareness campaigns in many parts of the country. NACA, in collaboration with UNICEF undertook a massive awareness raising campaign which reached 3 states of the country. In collaboration with the Society for Family Health with support from DFID and USAID, NACA have supported messages for radio and TV focusing on avoiding HIV infection through abstinence, mutual fidelity and the use of condoms. NACA has also inserted a few full-page adverts on the facts of HIV/AIDS in major national dailies.

The John Hopkins University Health Communication Programs JHU/HCP (USAID) supports a telephone hotline service in Lagos State which has proved to be very popular, with calls coming in from different parts of the country in spite of the fact that such calls are not toll free. There is a real need for the establishment of more of such centres that provide services toll-free. The Policy Project (USAID), working with the NGO Journalists against AIDS (JAAIDS), has developed a Nigeria-AIDS website (www.nigeria-aids.org) for electronic dissemination of HIV/AIDS activities in Nigeria and this is also proving to be very popular especially among those with internet access both nationally and internationally.

The Performing Musicians Association of Nigeria (PMAN) and other artistes have held a few concerts to promote AIDS awareness. MTN now sends free SMS messages to all their subscribers at least once a month on HIV/AIDS prevention and care. The Coca-Cola Company is now preparing to contribute to national communication efforts. All these efforts have however tended to be sporadic and have not been sustained, most public awareness activities being concentrated around World AIDS Day. Messages used by the mass media to promote safe sexual practices are often inappropriate because field testing for the appropriateness of these messages in different cultural contexts were not carried out. Several media houses and advertising professionals also fail to recognize the stigmatization potential of the kinds of language they use in their broadcasts and publications.

Recently the government in partnership with UNICEF launched a massive awareness campaign. However recent studies show that awareness is quite high at over 88%⁸. Though rural populations were less aware (83%), it is obvious that a lot of awareness-raising has already taken place even with rural communities. Evidence from research and surveys will suggest a change in strategy from awareness-raising to knowledge-building.

Increasing Knowledge on HIV/AIDS

One of the major strategies for controlling the epidemic is to increase the knowledge of citizens on the modes of transmission of HIV and how to take adequate steps to protect themselves. Numerous small scale activities towards increasing the knowledge of Nigerians on HIV/AIDS occur daily. Small-scale public and private initiatives continue in different parts of the country. The major challenge is the tendency for most activities to occur in the urban areas. Recent surveys show that urban dwellers are more knowledgeable on HIV issues than the rural folk. There is also misconception around the effectiveness of awareness creation programs improving knowledge. Behavioural surveys and individual research work have however shown clearly that while awareness of HIV/AIDS has increased considerably, knowledge and understanding of HIV/AIDS transmission modes is only fair and that misconceptions still exist. Also wrong impressions exist about treatment options, and the correct attitude to be shown to PLWHA.

⁸ National HIV/AIDS and Reproductive Health Survey, Nigeria 2003

60% know that a HIV infected person may appear healthy

51% of people know 2 methods of preventing against sexual transmission of HIV

Only 19% of persons have complete knowledge on HIV transmission

Source: 2003 National HIV/AIDS & Reproductive health survey

Condom Promotion, Availability and Use

The Society for Family Health through a seven year program funded jointly by DFID and USAID in collaboration with the Federal Ministry of Health and NACA are the agencies leading condom promotion through a social marketing paradigm. A large distribution network has been developed to ensure that condoms are available to all who need to use them.

The factors affecting condom use include the availability and the affordability. By increasing the coverage of the country and highly subsidising the price, condoms are nearly universally available. The main hindrances to uptake and use include people's perception of the condom effectiveness, their effect on sexual satisfaction, and shyness of persons to buy condoms over the counter to avoid societal labelling as promiscuous. Increasingly though these barriers are being overcome and when condoms are distributed through non-traditional outlets e.g. hotels, offices, playgrounds, meetings etc., uptake has been extremely high. In spite of this many other barriers exist to the use of condoms. These include opposition by social institutions such as religious organisations and traditional societies. The emphasis on ethnic politics and numbers have led a lot to believe that the use of condoms is an attempt to reduce their political strength and clout.

Community Mobilization

NACA and the Federal Ministry of Health have commenced some activities in this regard but this is still in its infancy. Most efforts to date have been led by NGOs and have been concentrated in a few States. The World Bank, DFID, United Nations Children's fund (UNICEF) and USAID (through IPs) have contributed to supporting pilot initiatives.

Behaviour Change Communication Strategy

JHU/HCP has been working with the National Action Committee on AIDS (NACA) to develop a national behaviour change communication (BCC) strategy. NACA also recruited a consultant community mobilization specialist to work on the articulation of this strategy. The plan is nearly completed. International community mobilization organizations e.g. Humana People to People have shown an interest in contributing towards these efforts using their TCE (Total Control of the Epidemic) approach first applied in Botswana in one pilot state but this is yet to receive the blessings of the new leadership of NACA.

Treatment of STI

In the early advent of HIV/AIDS, a lot of emphasis was placed on the treatment of STI as a method of protecting persons from getting infected with HIV. This led to the development of syndromic management of STI at centres that did not have good laboratory facilities. This initiative was led by WHO and some implementing partners of USAID. Lately there is less emphasis on this strategy as a mode of prevention and will need redressing if the transmission potential of HIV from other STIs is to be minimized.

Voluntary Counselling and Confidential Testing

There is a need to institutionalise VCT because of its overwhelming benefits in both prevention and care. Voluntary counselling and testing services in Nigeria exist on a small scale. Most VCT services are stand-alone sites operated by NGOs in a few states in the country. Institutionalising VCT services will include building the capacity of NGOS already involved in VCT and linking them up with institutions to provide continuum of care. The Federal Government of Nigeria and a few developmental partners are now addressing this and it is hoped that in the next couple of months several of these linked to the PMTCT and ARV sites as well as stand-alone sites will become widely available. Initial projections are for the establishment of a minimum of 100 sites spread evenly across the country.

Screening methodologies are not uniform. WHO has provided technical assistance in the development of appropriate screening methodologies but these are yet to be universally implemented. The Federal Ministry of Health, on a cost reimbursable basis to health institutions, has provided most screening kits. The kits until 2001 were mainly procured by DFID, though the US Centres for Disease Control (CDC) provided kits used during the 2001 and 2003 sentinel surveys and will likely be providing more under the new US Presidential Initiative on PMTCT and the rapid expansion of the ARV program.

Family Health International (FHI) also has plans to introduce an additional 20 VCT centres up from the current 2 they established in Lagos and Kano.

The cost of testing in public health facilities is much smaller than what obtains in private settings. Though HIV testing does occur in governmental institutions this is usually done on the doctor's recommendation. No protocols exist within most government health institutions for persons just voluntarily opting to know their status. Such persons use the services offered by NGOs or private laboratories. Unfortunately, most individuals are also unable to meet the cost of HIV screening in the private unsubsidised facilities that exist. Another problem with these laboratories is that most of them test without appropriate counselling.

The number of trained counsellors, screening and counselling centres continues to improve but still requires massive scaling up. The Federal Ministry of Health has written guidelines for counselling services but these are yet to be widely disseminated. FHI, Pathfinder and Engender Health (USAID) have been in the forefront for training counsellors. However activities are limited to very few States. Several smaller NGOs also claim to train counsellors. The content of these courses is not known. Major challenges are the disseminating the guidelines and ensuring their adherence in both private and public institutions; determining the skills required by trained counsellors, developing a curriculum to meet these needs and ensuring conformity in training institutions.

Quality control of testing procedures is expected to be undertaken by the research laboratories. The Nigerian Institute for Medical Research (NIMR) has commenced operation of their HIV/AIDS research and testing laboratory supported by a Ford Foundation grant. This now supplements facilities present at the Nigerian Institute for Pharmaceutical Research and Development (NIPRD) and one being developed at the Jos University Teaching Hospital with funds from the AIDS Prevention Initiative in Nigeria (APIN). These institutions however only offer quality control for public institutions and only those offering ARV or PMTCT services. There is very little control for private institutions and NGOs.

Prevention of Mother to Child Transmission

The PMTCT programme started off with pilot schemes in some of the federal health institutions with the support of UNICEF. Through the six initial sites, practical lessons were to be learnt which were to inform future programme expansion. The expected lessons were to be in the area of logistics, human resource requirements, and service guidelines. An additional five sites were added to the scheme with the support of developmental partners including the Bill Gates Foundation and the Centre of Disease Control, Atlanta, USA. These were also to use the technical expertise of their partners to foster

lessons learnt. The program is now poised for considerable expansion to be supported largely with Federal Government of Nigeria funds, and funds from the US Presidential Initiative on HIV/AIDS and the Global Fund for AIDS, TB and Malaria.

The program though still in its infancy has already started showing challenges in coordination. The different sites had varying procedures of implementation with disparities in services being offered at different sites. These differences were based on the varied focus of the developmental partners. Most persons, especially the health workers on the field, saw the initiatives as projects of the developmental partners involved. The FMOH (NASCP) is finding it difficult to coordinate all the players due to a limitation of government funds, which forces them to rely on partners to fund their supervisory visits and program reviews.

Some lessons are already evident. They include the fact that HIV/AIDS education among health workers at the sites should have commenced long before the commencement of the programs to reduce or eliminate stigma and discrimination expressed by health workers. This should have included adequate education of health workers on the practice of universal precautions and the adequate provision of hospital supplies to practice it. Another lesson from hindsight is that the VCT services should also have pre-dated the PMTCT services – as things now stands, it seems as if the main function of VCT services is to screen pregnant women. Other factors that are noted to be affecting the program include the poor remuneration for public sector health workers involved in the project; logistics issues around ARV, testing kits, and breast milk substitutes, and the upgrading of facilities at project sites including laboratory facilities

In spite of the challenges the program shows a lot of promise. An operational research is being carried out to determine the sticky issues and to highlight problem issues to be resolved before program expansion. The country was given support through the Global fund to scale up the program. The U.S. President Bush's HIV initiative is focused on providing PMTCT services and Nigeria is a beneficiary. A Core Partner's Forum has been formed to advise government on policy direction for PMTCT, to improve coordination for redefining PMTCT goals, improving quality control, monitoring and evaluation, operations research, and mobilising resources for the program.

Blood Safety

Blood safety policy guidelines for implementation exist developed by the Federal Ministry of Health with support from international collaborators. However, implementation is only restricted to major Federal and State Health institutions and a few select private hospitals. Considering the fact that most

Nigerians usually use private health facilities, this is not adequate. The standards for screening are not widely known outside the government facilities. Screening kits vary in terms of sensitivity and in a country with a high prevalence of HIV the tendency for some blood to be wrongly labelled negative is considerable. NACA, FMOH and NAFDAC are working on ensuring adequate validity of HIV test kit before allowing their use in the country. Nigeria is also using Determine[®] as its current gold standard for test kits for the 2003 sentinel survey and other screening tests.

The new policy states that both federal and state governments should jointly develop a minimum 'standard of practice' for blood banking institutions in the country, while the states are to take on the task of accrediting such institutions within their states and monitoring the compliance with the standards set. Hitherto enforcement of regulations had been weak. It must be stated though that blood banking services in Nigeria are largely inadequate.

Legislation and protection of Human rights

No specific legislation exists on HIV/AIDS or for the protection of the rights of those infected or affected. Discrimination and stigmatization are still rife and examples of discrimination abound. The national HIV/AIDS policy states that "*persons living or affected by HIV shall not be discriminated against on the basis of their health status with respect to education, training, employment, housing, travel, access to health care and other social amenities and citizenship rights*". The Federal Ministry of Labour in a tripartite arrangement with the labour unions and the employers of labour have negotiated a Workplace HIV/AIDS Policy. It is hoped that the policy will be launched and widely disseminated in 2004. Some of the key policy statements includes that no person's employment could be terminated as a result of his/her HIV status and that HIV screening is not a requirement of the pre-employment medical examination, re-emphasising what is in the national policy.

The challenge will then be to ensure that companies adapt the policy to their conditions, formulating workplace programs which include a policy, and HIV/AIDS prevention, care and support interventions for their employees and their host and neighbouring communities. The national response has as one of its strategies, to reduce level of stigma and discrimination shown to PLWHA. A number of sensitisation and awareness campaigns have been carried out on the effect of stigma, seeking behaviour change. The Federal Ministry of Labour has helped a few PLWHA wrongfully terminated on the basis of their HIV status. A few NGOs and the Network of People Living with HIV/AIDS have

also been active in offering support to the aggrieved. Some individuals and human rights organisations have even helped PLWHA seek legal redress.

The HIV/AIDS policy states the country's intent to codify all HIV relevant legislation. Work is yet to start on this. The policy also affirms the nation's intent to review relevant legislation and enact appropriate new laws to protect the rights of all citizens especially PLWHA.

Care and Support Initiatives

Home Based Care

One of the strategies being adopted in the national response is the provision of home based care to PLWHA. Because this infers care at the community level, the strategy is being led by the National Primary Health Care Development Agency (NPHCDA), a parastatal of the Federal Ministry of Health. While strategies have been developed very little has occurred. Budgetary support for these activities is extremely limited, thus the bulk of the work is still being carried out by NGOs and FBOs who in turn, depend largely on funding from international donor agencies. Key funders of NGOs in this area include the Ford Foundation, McArthur Foundation, DFID, USAID, UNICEF, International Labour Organization (ILO), and United Nations Organization for Women activities (UNIFEM).

The challenges of stigma and discrimination have limited the amount of work done in this strategy. Obtaining volunteers is also hard.

Care of Orphans and Vulnerable Children

The government has done very little work in this meeting the needs of this group. The country has just completed a plan of action with multi stakeholder participation assisted by UNICEF and Policy Project. This plan charts a way to move the OVC agenda forward and commence with a situation analysis funded by the World Bank which is now to be followed by a national conference to increase visibility for this program. The lead organisation for the government is the Federal Ministry of Women's Affairs and Youth Development.

Some organisations including CEDPA, Africare and Hope Worldwide have carried out localised activities which have provided valuable lessons that could inform future programs and activities. Many Faith based organisations have actually been in the forefront of providing the needed care but due to a lack of documentation, a lot of the knowledge acquired is not available for future

programming. Hopefully current increased linkages by the public sector and development partners with faith based organisations should improve upon this lapse. Some organisations have started micro credit schemes for persons living with HIV/AIDS, and persons affected by it, to overcome the poverty associated with the condition. These activities are still in their infancy and are yet to show evidence of their effectiveness.

Antiretroviral Therapy Programme

In a massive paradigm shift, the Federal Government of Nigeria has embarked on one of the largest public health subsidised ‘access to anti-retroviral drugs (ARV) programs’ in the world. Initially a pilot program on use of these drugs was commenced and 250 persons living with AIDS (PLWHA) benefited. This was expanded and now about the twenty five centres are offering 10,000 persons with AIDS antiretroviral therapy. Five thousand children are now also expected to benefit, the delay in starting occasioned by fears of the unknown effects the drugs might have on children. With benefit of lessons learnt from the adult ARV program, protocols have now been developed and this program should commence in 2004.

The ARV program was met with wide enthusiasm by those who could benefit from it. The program is already fully subscribed and in many centres, oversubscribed. There are more on the waiting list than those on therapy. Unfortunately though the cost of the drugs is subsidised, the cost of the other inputs into the program including the various tests that have to be done are quite expensive. This leads to further impoverishment of the persons on treatment and limited uptake by those not certain of their ability to meet these additional costs. For those who cannot access the government initiative, major pharmaceutical companies with offices in Nigeria have announced in concert with the current global trend, reductions in the cost of ARV. However, these reductions still fall far short of what is affordable by the majority of those infected. The potential for drop-out by those already on treatment and the implications for development of resistance to these drugs also remains high.

For how long this program can be sustained is uncertain. The newly launched Health Insurance Scheme in Nigeria also makes no provision for supporting those needing anti-retroviral therapy. After a lot of advocacy it has accepted to meet the health needs of persons living with HIV/AIDS. The Federal Ministry of Health recently was allocated funding from the global fund to scale up the provision of ARV. Draft guidelines on drugs administration, distribution, monitoring and evaluation have been developed and will continue to be refined as the program progresses.

Treatment of Opportunistic infection

There is a feeling expressed by many, including the network of People living with HIV/AIDS, that the perceived emphasis on the ARV therapy deflects attention away from other programs which could delay the need for ARV such as nutritional counselling, early treatment of opportunistic infections and the possibility of prophylactic therapy against common opportunistic infections such as Tuberculosis. It also makes it less likely that home based care will receive the interest it deserves. This could have dire consequences for those who are unable to access ARV as a result of poverty or distance.

Drugs needed to treat opportunistic infections and other ailments are in short supply, not always affordable, and often adulterated and of poor quality. The adulteration of drugs is being tackled aggressively by the National Food and Drug Control Agency but the proportion of fake drugs on the market is still high.

The health workers are poorly paid and often poorly supplied with the necessary supplies to maintain universal safety precautions. They are not well motivated to care for PLWHA and exhibit some of the same stigma and discrimination tendencies seen in the general public towards PLWHA. The health facilities are therefore not PLWHA friendly and many PLWHA are not inclined to make use of health services as they should. Such infected individuals still largely patronize traditional medicine practitioners and faith healers who continue to profit from untested therapies on the gullibility of a largely illiterate population. These unpleasant practices thrive because of the lack of an enforceable regulatory environment for such practices.

Vaccine Development

The national HIV policy states that “the Federal Government of Nigeria through its academic and research institutions and ministries will extend the fullest possible cooperation, collaboration and support to the international effort to develop AIDS vaccines and drugs”. The development of candidate vaccines for Nigeria is still a long way off from clinical trials. There is no HIV/AIDS vaccine policy for the country though a vaccine plan/strategy has been developed by NACA, the Nigerian Institute for Pharmaceutical Research and Development (NIPRD), the Nigerian Institute for Medical Research (NIMR), the Federal Ministry of Health, various universities, UNAIDS, the International Agency for Vaccine Initiatives (IAVI) and several others. The strategy however lacks the funding to back it.

Research and Surveillance

The monitoring and evaluation of HIV interventions is weak. This responsibility for monitoring and evaluating the country's response is vested in NACA. Though it is presently working on a Monitoring and Evaluation plan, this is not yet operational. The only form of monitoring till date has been that from the health sector. In the health sector routine data collection and surveillance systems are not well established. There remains a large degree of underreporting with regards to routine case reporting and notification on HIV/AIDS⁹. However, sentinel surveillance has been scheduled every two years since 1991 with the last one in 2001. The 2003 survey is already underway and should be completed before the end of the year. Unfortunately due to a number of delays, it is likely that the published result will not be out till 2004. The sentinel survey done under the auspices of the Federal Ministry of Health is supported by WHO, DFID, USAID, UNAIDS, and CDC. The Policy Project provides assistance in the areas of data management, development of presentations and impact projections.

A Nigerian HIV/AIDS/STI Research Network was established recently and consists of researchers from the academia, research institutes, the Federal Ministry of Health and NACA. They have drawn up HIV/AIDS research priorities for the country but require sustainable funding and institutional support to be effective. The Harvard School of Public Health with funding from the Bill and Melinda Gates Foundation is carrying out comprehensive programs essentially research-based in Lagos, Oyo and Plateau states. The Japanese International Cooperation Agency (JICA) is also committed to supporting research activities through competitive grants to selected research institutions. Several others are also involved in carrying out research either as a basis for determining the kinds of programs to carry out, or to assess the efficacy and impacts of their programs or other interventions. There is a need to integrate the outcome of research into the national monitoring and evaluation system to ensure that lessons learnt through research are not lost but benefit present and future interventions.

The National Action Committee on AIDS is still developing its monitoring and evaluation plan which is yet to be implemented. The nation therefore has only scanty information on the volume of activities undertaken in the national response and its effects. One major point of concern to the donor agencies is the poor state of financial monitoring in transparency in the country. Till date it is difficult to account for money that is said to have been used for program activities. The lack of an ability to track funds

⁹ FMOH, 2001, Department of Research Planning and Statistics, *Report of Notification of HIV/AIDS Cases*.

may also be a reason why Nigeria does enjoy per capita funding parity with other developing nations. The Nigerian National Response Information Monitoring System (NNRIMS), which is being developed by NACA should if properly run should be able to track both finances and activities. Unfortunately many other information management systems have not been successful as a result of logistics difficulties. Without adequate support it is possible that the NNROMS may suffer the same fate.

Impacts

It can be fair to say that intervention programs to date have not had very significant impact in stemming the epidemic as the results from previous sentinel surveys show a steady rise in the prevalence of HIV sero-positivity. Recent anecdotal reports indicate a continuing rise in prevalence from select populations and laboratory facilities around the country. Those reported to be the most affected remain the youths and adolescents.

Despite this rise, reports of studies carried out by the Federal Ministry of Health and several other agencies show that there has been a steady increase in awareness of HIV/AIDS. In the last behavioural survey 88% of persons had heard of HIV/AIDS¹⁰. There is also an increase in knowledge of HIV/AIDS transmission modes and protective measures especially in the urban areas though this is far from reaching acceptable levels. Unfortunately this knowledge is not yet associated with the desired behaviour change. Having multiple sexual partners is still rife, sexual relationships with non-regular partners still occurs a lot, especially among the youth (15 – 24 years), low use condoms with non-regular sexual partners persists, and a high level of discriminatory attitudes and practices are still directed towards people living with HIV/AIDS.

- 9% of women and 19% of men engage in risky sexual practices
- Youths are more at risk: as many as 26% of male and 14% of female youth respectively practice risky sex
- Only 32% of women and 50% of men use condoms during risky sex

Source: 2003 National HIV/AIDS and Reproductive Health survey

¹⁰ Federal Ministry of Health 2003. National HIV/AIDS and Reproductive Health Survey

These results are not surprising since the country is still building up the desired momentum for its response. The behaviour change communication strategy is still being formulated. Behaviour changes are slow and many initiatives including the family life & HIV/AIDS education curriculum is yet to commence in a meaningful way in many states of the federation.

Conclusion

The fact that the epidemic has only just crossed the theoretical 5% prevalence threshold for entering the explosive phase of the epidemic, presents the greatest opportunity for a proactive national response. Now is the time to provide the requisite support to ensure that government at all levels realize the magnitude of the problem confronting them and to assist them and their communities to take their destiny in their hands.

The content of the national response appears adequate in terms of what is known and what is conceived, however many interventions are yet to take off for lack of funds and many that have taken off are in need of massive scaling up. There is a need to articulate an effective behaviour change communication strategy for the country and effectively implement it. There is a need for considerable community mobilization strategies including mass media campaigns. There is a need to establish additional voluntary counselling and testing centres. There is a need for increased access to drugs for prophylaxis, treatment of opportunistic infection and ARV. There is a need to start implementing the Family life education curriculum in schools. There is a need adopt measures to protect the rights of persons living with HIV/AIDS. There is a need for an articulate plan for the care of orphans and vulnerable children.

There is also an urgent need to build up and develop of capacity of the NACA secretariat to do the job that has been committed to NACA. NACA's capacity to coordinate and monitor the national response is critical to the successful control of the epidemic. A major challenge in the country presently is a lack of monitoring and evaluation of programs and a lack of operational research to understand the problems in the programs and improve upon them.

Though starting late, Nigeria has some in-country technical capacity and the support of many developmental partners. Since Nigeria's return to democracy, it has received support from all of its old partners and quite a number of new ones. The funding for HIV interventions has been steadily increasing. There is an acceptance by the leadership that the epidemic needs to be stemmed and a lot of commitment to see it done. Old sceptics of the national response are now becoming advocates.

The organized private sector, the faith based organizations and states governments are gradually building up to take a more definitive role in contributing towards the national response. Nigerians in the face of the Herculean task ahead are rallying together to ward off a human disaster of monumental proportions. Nigerians pray. We look forward to Nigeria becoming another success story in the fight against HIV and AIDS.

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